Quality is Our Bottom Line

Insurance and Real Estate Committee

PUBLIC HEARING

Tuesday, March 5, 2019

Connecticut Association of Health Plans

Testimony regarding

H.B. No. 7125 AN ACT CONCERNING PARITY FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS, NONQUANTITATIVE TREATMENT LIMITATIONS, DRUGS PRESCRIBED FOR THE TREATMENT OF SUBSTANCE USE DISORDERS, AND SUBSTANCE ABUSE SERVICES.

The Connecticut Association of Health Plans welcomes the opportunity to work with the Committee members on H.B 7125.

The carriers are proud of the work they've done historically in furtherance of mental health and substance use parity. It's important to recognize that Connecticut already has a robust set of statutes in place including well established mental health parity laws and provisions that expedite benefit determinations and mandate certain protocols upon which coverage decisions are made as follows (excerpted from OLR summaries):

In accordance with Sec. 38a-591c, for services or treatments relative to (1) substance use disorders or co-occurring mental disorders and (2) mental disorder-related inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a covered person from requiring an inpatient setting, the law requires a carrier to make its determination as soon as possible, but no later than 24 hours after it receives a service or treatment request for these disorders.

By classifying requests for these services and treatments as urgent, the act entitles the covered person to an expedited review of an adverse determination. In general, a carrier or independent review organization (an entity unaffiliated with the carrier that conducts an external review) must notify the covered person and his or her representative of its decision regarding an expedited review within 72 hours of receiving a grievance. But, for expedited reviews involving mental and substance use disorders as specified above. such notice must be provided within 24 hours.

By law, each plan must use documented clinical review criteria based on sound clinical evidence. Specific requirements are set out in statute for clinical review criteria for utilization review involving substance use or mental disorders.

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Carriers must develop, purchase, or license clinical review criteria for substance use, child or adolescent mental, or adult mental disorders that addresses advancements in technology or the type of care for treating these disorders not covered in the most recent edition of the professional medical society publications for these disorders.

Under current law, any criteria developed, purchased, or licensed to treat these disorders must be based on sound clinical evidence and evaluated periodically. Carriers may still choose to adopt criteria in, or demonstrably consistent with, the medical societies' publications. If they choose the latter, the act specifies they must demonstrate the criteria's consistency to the insurance commissioner. Carriers are required to post on their websites any clinical review criteria they use and links to any rule, guidelines, protocol, or other similar criteria they rely on to make an adverse determination decision.

With the exception of the provision above relative to advancements in technology and care, the law generally requires health carriers to adopt the criteria published in, or develop criteria demonstrably consistent with, the following publications:

1. American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, for substance use disorders;

2. American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument guidelines, for child or adolescent mental disorders; or

3. American Psychiatric Association guidelines or the Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare, for adult mental disorders.

Our plans have been at the forefront of establishing best practices in the areas of mental health and substance use services supporting innovative approaches that embrace medication assisted treatment among other levels of care.

As we move forward, we respectfully ask that the legislature be mindful of where the appropriate regulatory authority for the industry lies so that the state does not set up a system of dual regulation that adds considerable confusion, administrative burden and cost to the system. Likewise, we ask that you build on existing structures and data platforms that can provide the state with clear and meaningful information for purposes of analysis. Most importantly, we respectfully suggest that you remove the provisions related to pharmaceutical management which, by virtue of the associated costs, will have the unintentional effect of reducing access to care as opposed to increasing it. Lastly, the carriers request that effective dates be pushed out to allow for the appropriate implementation schedules.

Thank you for your consideration.